

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

17386

## CERTIFICATE OF DEATH

107377  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b <b>4 WEEKS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL Hospital</b>		e. STREET ADDRESS <b>CHAPTICO (RURAL) 18112</b>			
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>THORNTON</b>	Middle <b>KINSEY</b>	Last <b>BRIDGETT</b>		
4. DATE OF DEATH	Month <b>JULY</b>	Day <b>7</b>	Year <b>1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W-US</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 29, 1903</b>		
9. AGE (In years last birthday) <b>54</b>	10. IF UNDER 1 YEAR (IF UNDER 24 HRS. Months <b>54</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>HAMMOND BRIDGETT</b>	14. MOTHER'S MASTERN NAME <b>MATTIE ST. CLAIR.</b>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>213-72-0935</b>	17. INFORMANT <b>MRS. THORNTON BRIDGETT, CHAPTICO, MD.</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Deutschweiler</b>	(County) <b>Frederick</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>JANUARY 1957</b> to <b>JULY 7, 1957</b> , that I last saw the deceased alive on <b>JULY 7, 1957</b> , and that death occurred at <b>Deutschweiler</b> M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>John W. Giffen M.D.</b> PHYSICIAN'S NAME (Type) <b>Hughesville, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Graveside</b>	22b. DATE THEREOF <b>7-10-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Hentschel M.</b>	22d. LOCATION (City, town, or county) <b>Deutschweiler</b>	(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reburt Inc. La Plata</b>	ADDRESS <b>700</b>	24a. REC'D BY REGISTRAR DATE <b>7/19/57</b>	24b. REGISTRAR'S SIGNATURE <b>Julia H. Rosey</b>		

STATE DEPARTMENT OF HEALTH-ENVIRONMENT  
CERTIFICATE OF DEATH

BUREAU V. S.

JUL 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07387

## CERTIFICATE OF DEATH

07379  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Dentsville	c. LENGTH OF STAY IN lb Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Dentsville.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE First A. Middle Len COOKSEY		4. DATE OF DEATH JULY 12 1957	
5. SEX Male	6. COLOR OR RACE US-W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17, 1879
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
10c. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matchais A. COOKSEY		14. MOTHER'S MAIDEN NAME Sarah E. Hancock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. -	
17. INFORMANT ERNEST COOKSEY		Address Dentsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0 DUE TO Respiratory failure.		5 min.	
Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause last. (b) Cerebral vascular accident. DUE TO		5 hrs.	
(c) Generalized arterosclerosis.		10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PC fell off of back step and hit his head.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PC fell off of back step of his home.	
20c. TIME OF INJURY Month, Day, Year Hour 8:20 p.m. July 11 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 170 ME 20f. (City or town) (County) (State) Dentsville, Chas. Md.	
21. I certify that I attended the deceased from May 1947, to 12 July 1957, that I last saw the deceased alive on 12 July 1957, and that death occurred at (2:2) AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) La Plata, Md.	
ACTUAL SIGNATURE ARTHUR O. WOODY		DATE SIGNED	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY			
22a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL		22b. DATE THEREOF 7-15-57	
22c. NAME OF CEMETERY OR CREMATORIAL DENTSVILLE CEM.		22d. LOCATION (City, town, or county) (State) DENTSVILLE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS WALDORF, Md.	
VS A15 (4) 1SM 9/55		24a. REGD BY REGISTRAR JUL 16 1957	
		24b. REGISTRAR'S SIGNATURE Julia Pacey	

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 16 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 24 hours after death. The body or copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1

## CERTIFICATE OF DEATH

07388

Reg. Dist. No. 101

## 1. PLACE OF DEATH

COUNTY

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

MARYLAND

LENGTH OF STAY  
(in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET  
ADDRESS3. NAME OF  
DECEASED  
(Type or Print)

(First) (Middle) (Last)

S. SEX

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)10b. KIND OF BUSINESS  
OR INDUSTRY

10c. BIRTHPLACE (State or foreign country)

10d. AGE last birthday

10e. IF UNDER 1 YEAR

10f. IF UNDER 24 HRS.

10g. Months

10h. Days

10i. Hours

10j. Min.

11. DATE OF BIRTH

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

18. MEDICAL CERTIFICATION

19. IMMEDIATE CAUSE

20. AUTOPSY?

21. ANTECEDENT CAUSE(S)

22. DISEASES OR CONDITIONS, IF ANY,

23. GIVING RISE TO THE ABOVE CAUSE

24. STATING UNDERLYING CAUSE LAST.

25. DUE TO

26. DUE TO

27. DUE TO

28. DISEASES OR CONDITIONS, IF ANY,

29. GIVING RISE TO THE ABOVE CAUSE

30. STATING UNDERLYING CAUSE LAST.

31. INTERVAL BETWEEN  
ONSET AND DEATH

32. BREAST CANCER

33. CARDIAC INSUFFICIENCY

34. 20. AUTOPSY?

35. YES  NO 

36. DATE

37. (State)

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WISCONSIN STATE POLICE DEPARTMENT, WI

CERTIFICATE OF DEATH

BUREAU  
JUL 30 1968  
FBI

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117381

(7389)

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Physicians Memorial Hospital				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 2401 Southern Ave. S. E. Wash. D. C.				
3. NAME OF DECEASED (Type or print) Jean		First Middle Last Marie Gonzales	4. DATE OF DEATH July 12/1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12/1957			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Charles County			
13. FATHER'S NAME Alfred A. Gonzales		14. MOTHER'S MAIDEN NAME Barbara Jean Cassell	12. CITIZEN OF WHAT COUNTRY? America			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT mother 2401 Southern Ave. Wash. D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7-12-57 Atlectasis Pneumatury (30wks) 7-12-57 At 3# 6oz				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lafayette	(County)	(State)
21. I certify that I attended the deceased from 7-12-57 to 7-12-57 that I last saw the deceased alive on 7-12-57 1957, and that death occurred at 417 m. from the causes and on the date stated above. ADDRESS (Street, city or town, state)						
ACTUAL SIGNATURE E. J. Edelen	M.D.		DATE SIGNED 7-12-57			
PHYSICIAN'S NAME (Type) E. J. Edelen	E. J. Edelen, M. D., La Plata, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7-15-57	22b. DATE THEREOF 7-15-57	22c. NAME OF CEMETERY OR CEMATORIUM Sacred Heart La Plata	22d. LOCATION (City, town, or county) La Plata	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Richard Lee Lafayette	ADDRESS 2066182 X 12	24a. REC'D BY REGISTRAR DATE 7/18/57	24b. REGISTRAR'S SIGNATURE Julia B. Parry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y. S.  
REC'D BY  
JUL 22 1957

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 15-5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07382

07390

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HOSPITAL OR INSTITUTION STREET ADDRESS	CHARLES HUGHESVILLE Rt. #5 north of village	MARYLAND LENGTH OF STAY (in this place) VISITING (2WKS)	STATE MARYLAND COUNTY ST. MARY'S CITY (If outside corporate limits, write RURAL and give nearest town) TOWN MECHANICSVILLE 18X02 STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH July 23 (Day) 19 57 (Year)				
5. SEX FEMALE	6. COLOR OR RACE W-US.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH Sept. 3-1885 71 9. AGE last birthday 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER (RETIRED)	10b. KIND OF BUSINESS OR INDUSTRY TEACHING	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Raphael S. Jarboe		14. MOTHER'S MAIDEN NAME Elle L. Stewart				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. —		17. INFORMANT & ADDRESS MRS. Forbes BOWLING - Waldorf Md.		
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 33IX IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE, ACUTE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) ESSENTIAL HYPERTENSION GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST, DUE TO STATING UNDERLYING CAUSE LAST, DUE TO (C) — INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES 10 YEARS						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from July 23, 1957, to July 23, 1957, that I last saw the deceased alive on July 23, 1957, and that death occurred at 1045 A.M. from the causes and on the date stated above. SIGNATURE John H. Guffin, M.D. ADDRESS (Street, city, town, state) Hughesville, Md. DATE SIGNED 7/23/57						
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-26-57		NAME OF CEMETERY OR CREMATORIUM ST. JOSEPH Cem		
24. REC'D BY REGISTRAR DATE 7/26/57		REGISTRAR'S SIGNATURE Maurice D. Stansbury		LOCATION (City, town, or county) MORGANZA, Md.		
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS P. B. Robinson - Leonardtown, Md.						

RECEIVED IN THE STATE ARCHIVES OF PENNSYLVANIA

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 29 1957

RECEIVED

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07383

## 7391 CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY TOWN STREET ADDRESS
Harford La Plata	MARYLAND La Plata	Md La Plata	Gloucester
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF (First) (Type or Print)	(Middle)	(Last)	4. DATE (Month) 1951
George W. Johnson			7 27 1951
5. SEX Male	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Feb 10 1891
			9. AGE last birthday 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Johnson	14. MOTHER'S MAIDEN NAME Willie Stoney		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 444-44-4444	17. INFORMANT & ADDRESS John Johnson - S. O. P. A.	INTERVAL BETWEEN ONSET AND DEATH 1 year
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Gastro-intestinal Cancer ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 444X Hyperthyroidism 10 years			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) La Plata	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 1, 1951, to July 26, 1951, that I last saw the deceased alive on July 1, 1951, and that death occurred at 12:00 A.M., from the causes and on the date stated above. SIGNATURE: J.W. Johnson M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF July 26, 1951	NAME OF CEMETERY OR CREMATORIUM Sacred Heart, La Plata, Md.	LOCATION (City, town, or county) La Plata, Md.
24. REC'D BY REGISTRAR Julia Posey	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE Harold Funeral Home, Inc.	ADDRESS
DATE JUL 26 1951			

REGELAHL  
JUL 26 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07392

## CERTIFICATE OF DEATH

07385  
106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road, home</i>		c. LENGTH OF STAY IN 1b <i>here</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
3. NAME OF DECEASED (Type or print) <i>JOHN</i>		First <i>WESLEY</i>	Middle <i>KEY</i>	
4. DATE OF DEATH <i>July 1, 1957</i>	Month <i>July</i>	Day <i>1</i>	Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 11, 1875</i>	
9. AGE (In years, months, days) <i>81 yrs.</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS. <i>Days</i>	12. IF UNDER 24 HRS. <i>Hours</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>merchant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Louis Key</i>	14. MOTHER'S MAIDEN NAME <i>Victoria King</i>	Address <i>J. Wesley Key Jr. Bryans Road, Md.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>J. Wesley Key Jr. Bryans Road, Md.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c) <i>Hyperensive Ht. Disease</i> DUE TO (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Trouble</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Trouble</i>		
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19 p.m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>	20f. (City or town) <i>1710 Col Rd., N.W. Wash., D.C.</i>	(County) (State)
21. I certify, that I attended the deceased from <i>June 23, 1957</i> to <i>July 1, 1957</i> , that I last saw the deceased alive on <i>July 1, 1957</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John G. Todd</i> PHYSICIAN'S NAME (Type) <i>John G. Todd, M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>7-4-57</i>	22b. DATE THEREOF <i>7-4-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Metropolitan Mort.</i>	22d. LOCATION (City, town, or county) <i>Comonkey, Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barney Matthews, 614 4th St. S.W.</i>	ADDRESS <i>Washington, D.C.</i>	24a. REC'D BY REGISTRAR <i>July 1, 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Ody Pease</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death; may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

В. С.

1957

СВЕДЕНИЯ

## 07393 CERTIFICATE OF DEATH

Reg. Dist. No. 10

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET (If rural give location)	
TOWN Indian Head				TOWN Rison		ADDRESS None	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dispensary, Naval Powder Factory, Indian Head, Md.							
3. NAME OF DECEASED (First) Lucian (Middle) Wilson (Last) KING				4. DATE (Month) (Day) (Year) OR DEATH July 13 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 8-15-26	9. AGE last birthday 30 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer			10b. KIND OF BUSINESS OR INDUSTRY Civil Service			11. BIRTHPLACE (State or foreign country) Rison, Maryland	
13. FATHER'S NAME James E. KING				14. MOTHER'S MAIDEN NAME Mary Monroe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 219 16 0864		17. INFORMANT & ADDRESS Wife - Rison, Maryland			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Occlusion ANTECEDENT CAUSE(S) DUE TO Coronary Artery Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Arteriosclerosis (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. HOW DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... 19 ..... to ..... 19 ..... , that I last saw the deceased alive on ..... 19 ..... ; and that death occurred at ..... M. from the causes and on the date stated above.							
SIGNATURE Joseph A. Murgals, LT MC USNR Dead on Arrival DATE SIGNED 7-13-57							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-16-57		NAME OF CEMETERY OR CREMATORIAL Pleasant Grove		LOCATION (City, town, or county) Maryland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE 7/14/57		Mary Smith		JOHNSON & JENKINS 1804 GAIAVE, WASH. D.C.			

RECEIVED  
JUL 18 1957

BUREAU V. S.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07387

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

07394

Item 7 Fil. G217 7-15-57 et

1. PLACE OF DEATH <i>Charles</i> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Laylata</i>		2. USUAL RESIDENCE (HOME) OF DECEASED <i>MARYLAND</i> LENGTH OF STAY (in this place) <i>1 year</i>		3. NAME OF DECEASED (Type or Print) <i>Winnie Palmer</i>		4. DATE OF DEATH <i>7 5 57</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>10-14-98</i>	9. AGE last birthday <i>59</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Richard Smith</i>		14. MOTHER'S MAIDEN NAME <i>Charity Lovell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>144-28-1234</i>	
17. INFORMANT & ADDRESS <i>Richard Smith, Laylata, Md</i>		18. MEDICAL CERTIFICATION <i>Charles Palmer, deceased by accident Hypertension Cerebral Vascular Disease</i>		19. DATE OF OPERATION <i>1957</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>No</i>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>None</i>		21c. WHERE DID INJURY OCCUR? (City or town) <i>None</i>		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>July 5 1957</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>None</i>			
22. I hereby certify that I attended the deceased from <i>6-30</i> , 19 <i>57</i> , to <i>7-5</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7-5-57</i> , and that death occurred at <i>4:30</i> P.M. from the causes and on the date stated above. ADDRESS (Street, city, town, state) <i>Laylata, Md</i> DATE SIGNED <i>7-5-57</i> SIGNATURE <i>Richard Smith</i>							
23. BURIAL CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7-6-57</i>		NAME OF CEMETERY OR CREMATORIAL <i>Louisville</i>		LOCATION (City, town, or county) <i>Louisville, Ky</i>	
24. REC'D BY REGISTRAR <i>Julia W. Parry</i>		REGISTRAR'S SIGNATURE <i>Julia W. Parry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Smith</i>		ADDRESS <i>Laylata, Md</i>	
DATE <i>7/9/57</i>							

REAU V. S.

JUL 11 1955

REGE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07388

Reg. Dist. No.

07395

1. PLACE OF DEATH a. COUNTY	Charles		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Indian Head		c. LENGTH OF STAY IN 1b	a. STATE
Indian Head				b. COUNTY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
			d. STREET ADDRESS	
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH
Vincent	JOSEPH	PETTA		July 24 1957

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-20-08	48 yrs.	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auto Mechanic	U.S.N.P.F.	NEW YORK	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Dominic Petta	Roserio <del>Antonio</del> Auricchio

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	II	PASQUALE Petta. 1524 Sycamore St Falls Church, VA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	1 min. 30 sec.
112.8	Compound fracture skull with
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) massive crushing face
DUE TO	
(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
None	

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
	Ats working electric fork lift which slipped off its support, top blocks

20c. TIME OF INJURY Month, Day, Year Hour a. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
855 7/24 1957	Factory	Indian Head Charles	07

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>
---

ACTUAL SIGNATURE	Frank A. Susan	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
---------------------	----------------	--	-------------

EXAMINER'S NAME (Type)	Frank A. Susan M.D. Acting	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL VANDER PLANT Funeral Home	22d. LOCATION (City, town, or county) (State)
REMOVAL	7-26-57		FAIR LAWN N.J.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Hunt Funeral Home	WALPOLE, MA.	29 1957	M. L. Murray Holley Crem.

BUREAU V. S

JUL 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07389

## CERTIFICATE OF DEATH

Reg. Dist. No. 102

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Neg Emory</i>		b. COUNTY <i>Charles</i>			
c. LENGTH OF STAY IN lb <i>45 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Neg Emory</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shamrock</i>		d. STREET ADDRESS <i>Neg Emory</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Shamrock</i>	First	Middle	Last		
4. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-20-57</i>		
9. AGE (in years, lost birthday) yrs <i>45</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>		
13. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	14. MOTHER'S MAIDEN NAME <i>Ruth Irene Gatzke</i>	Address <i>Wm A Possey Neg Emory, Md</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Wm A Possey</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>716x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Prematurity (6 month Premature)</i> INTERVAL BETWEEN ONSET AND DEATH <i>45 min</i>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>7/20</i> , 19 <i>57</i> , to <i>7/20</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7/20</i> , 19 <i>57</i> , and that death occurred at <i>545 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank A. Susan</i>					
ADDRESS (Street, city or town, state) <i>1100 Head St. Charles</i>					
DATE SIGNED <i>7/20/59</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-21-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>OTI Apel Church</i>	22d. LOCATION (City, town, or county) <i>Charles</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>None (Baby Buried by Father)</i>			24a. REC'D BY REGISTRAR <i>July 21</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. Thompson</i>	
VS A15 (4) 15M 9/55 4000266					

BUREAU

JUL 25 1957

KEGEI V E O

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 07397 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07390  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)						
<i>Charles</i> Tompkinsville Rural		a. STATE <i>Md</i> b. COUNTY <i>Charles</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <i>2 yrs.</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give the address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS						
<i>HERBERT GRANVILLE St Clair</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. SEX	4. DATE OF DEATH	5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years and months)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
<i>M</i>	<i>7</i> Month <i>30</i> Day <i>1951</i> Year	<i>M</i>	<i>W</i>		<i>9-10-90</i>	<i>67</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during month of working, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>SALESMAN</i>		<i>SHOC</i>		<i>St. Marys Co. MD.</i>		<i>U.S.A</i>		
13. MOTHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <i>577-05-5421</i> wife (now) Tompkinsville Md Address		
<i>Charles Henry St Clair</i>		<i>Frances Eleanor Herbert</i>		<i>No</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
						<i>Gunshot wound of head</i>		
						<i>Self inflicted</i>		
						<i>Severe cerebro-vas arteriosclerosis</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <i>8:30 a.m. 7-30-57</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, for- factory, street, office, bldg., etc.) <i>Home</i> 20f. (City or town) <i>Tompkinsville</i> (County) <i>Charles</i> (State) <i>Md.</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>7-30-57</i>		
22g. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		22e. DATE THEREOF <i>8-2-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Greenwood</i>		22d. LOCATION (City, town, or county) <i>Charles</i> (State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Herbert Lee LaPlaza - M.D.</i>		ADDRESS <i>111 Charles Ave LaPlaza - M.D.</i>		24a. REC'D BY REGISTRAR DATE <i>7/31/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Basye</i>		

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-510M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07391

## 07398 CERTIFICATE OF DEATH

Reg. Dist. No. .... 106 .....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	charles	MARYLAND	STATE
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN	Potomac Hts.		OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	COUNTY
3. NAME OF		(First)	(Middle)
(Type or Print)		MARGARET ORA Smith	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
F	W	MARRIED	1-30-1889
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
68	Housewife	Ohio	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Levi Tippy	Martha Stein		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
NO	—		
17. INFORMANT & ADDRESS			
Harold Smith, Potomac Hts- Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma Sigmoid Colon</u>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) <u>Cerebral Hemorrhage</u>			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH 3 months			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
Lyn.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
23/1			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		
	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>07 day</u> , 19 <u>56</u> , to <u>July 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>57</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above. SIGNATURE: <u>Frank G. Susan M.D.</u> ADDRESS: (Street, city, town, state) <u>Indian Head Md.</u> DATE SIGNED <u>7-4-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) <u>Washington D.C.</u> (State)
Cremation	7-5-57	Lee Funeral Home	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Ady Price</u>		
DATE <u>JUL 9 1957</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Elvert Funeral Home Washington, D.C.</u>		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07393

07399

## CERTIFICATE OF DEATH

Reg. Dist. No.

101

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>CHARLES</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARBLERY</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARBLERY</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not an hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>FANNIE L Washington</b>		First	Middle	Last	4. DATE OF DEATH <b>JULY 19 1957</b>	Month	Day	Year
5. SEX <b>FE male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1894</b>	9. AGE (In years last birthday) <b>63 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Ds Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>John Hudson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Dray</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHARLES Washington - MARBLERY, MD.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY INSUFFICIENCY</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>		
174 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) <b>SARCOMA OF UTERUS</b>				5 MOS		
		DUE TO (c) <b>GENERALIZED METASTASIS</b>				5 MOS		
PART II.—OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DIABETES MELLITUS				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>July 23, 1957</b> to <b>JULY 19 1957</b> that I last saw the deceased alive on <b>JULY 3rd, 1957</b> , and that death occurred after 200 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>Accokeek, Md. 7-19-57</b>		
ACTUAL SIGNATURE <b>Paul Chen</b>								
PHYSICIAN'S NAME (Type) <b>PAUL CHEN</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Mt. Hope Cemetery July 23, 1957</b>		22b. DATE THEREOF <b>July 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Hope Cemetery</b>		22d. LOCATION (City, town, or county) <b>Charles, MARYLAND</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Johnson and TANKINS</b>		ADDRESS <b>4804 Georgia Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>23-1957 Mary Sutherland</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 67400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

107394  
105

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newburg</i>		c. LENGTH OF STAY IN 1b <i>1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>11 NEWBURG</i>	
3. NAME OF -DECEASED (Type or print) <i>Guy</i>		First <i>Guy</i>	Middle <i></i>
4. DATE OF DEATH <i>7-16-57</i>		5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-7-85</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Washington</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>9</i>		16. SOCIAL SECURITY NO. <i>1-1-1-1</i>	
17. INFORMANT <i>Delila Chase (daughter)</i>		Address <i>4414 E St. SE DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>976x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7-16-57</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		Blew in flited 12 gauge <i>shot gun blast</i>	
DUE TO <i>(c)</i>		7-16-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>3 7-16 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Farm</i>		20f. (City or town) <i>Newburgh Chs</i> (County) <i>Charles</i> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Edelen</i>		DATE SIGNED <i>7-16-57</i>	
EXAMINER'S NAME (Type) <i>E. B. EDELEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-20-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Shilo Methodist Cemetery</i>		22d. LOCATION (City, town, or county) <i>Shilo Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>W. 1/2 St. Md.</i>	
24a. REC'D BY REGISTRAR <i>DATE 22-1957</i>		24b. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>	

DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WILDCAT EXAMINER'S COLLECTIVE OF DETROIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 8 Film G218 7-22-57 et 07395  
 07401 CERTIFICATE OF DEATH 106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road</i>	c. LENGTH OF STAY IN lb <i>18 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>Thomas Muschette</i>	First <i>Thomas</i>	Middle <i>Muschette</i>	Last <i>Wood</i>	4. DATE OF DEATH <i>July 8 1957</i>	Month <i>July</i>	Day <i>8</i>	Year <i>1957</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 26, 1879</i>	9. AGE (In years last birthday) <i>77 yrs</i>	10. IF UNDER 1 YEAR Months <i>7</i>	11. IF UNDER 24 HRS. Days <i>8</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Powder Factory</i>		11. BIRTHPLACE (State or foreign country) <i>Newmarket, Md.</i>		12. FATHER'S NAME <i>Brooks Muschette</i>					
13. FATHER'S NAME <i>Brooks Muschette</i>		14. MOTHER'S MAIDEN NAME <i>Mary Cecelia Wood</i>		Address <i>Bryans Road, Md.</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Annie A. Washington</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Chronic Myocarditis</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on <i>7/8/57</i> , 19 <i>57</i> , and that death occurred at <i>10 AM</i> , 19 <i>57</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank A. Susan M.D.</i>		ADDRESS (Street, city or town, state) <i>Indian Head, Md.</i>				DATE SIGNED <i>7/8/57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial July 12, 1957</i>		22b. DATE THEREOF <i>July 12, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Joseph's</i>		22d. LOCATION (City, town, or county) <i>Comptown, Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>July 15, 1957</i>				24b. REGISTRAR'S SIGNATURE <i>Odey Lucy</i>			

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CERTIFICATE OF DEATH

BUREAU V. S.

JUL 15 1957

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